Social Class and Mental Illness: A Community Study

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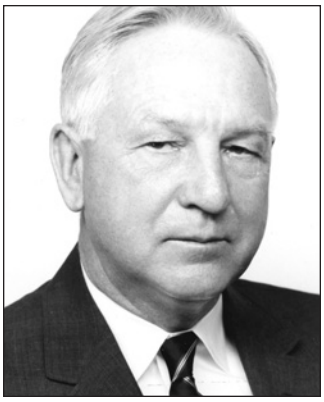

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AMERICANS PREFER TO AVOID the two facts of life studied in this book: social class and mental illness. The very idea of "social class" is inconsistent with the American ideal of a society composed of free and equal individuals, individuals living in a society where they have identical opportunities to realize their inborn potentialities. The acceptance of this facet of the "American Dream" is easy and popular. To suggest that it may be more myth than reality stimulates antagonistic reactions.

Although Americans, by choice, deny the existence of social classes, they are forced to admit the reality of mental illness. Nevertheless, the thought of such illness is abhorrent to them. They fear "mental illness," its victims, and those people who cope with them: psychiatrists, clinical psychologists, social workers, psychiatric nurses, and attendants. Even the institutions our society has developed to care for the mentally ill are designated by pejorative terms, such as "bug house," "booby hatch," and "loony bin," and psychiatrists are called "nutcrackers" and "head shrinkers."

Denial of the existence of social classes and derisive dismissal of the mentally ill may salve the conscience of some people. The suggestion that different social classes receive different treatment for mental illness may come as a shock, but to repress facts because they are distasteful and incongruent with cherished values may lead to consequences even more serious than those we are trying to escape by substituting fantasy for reality. . . .

Detailed evidence will be presented in this book to support the answers we have reached. If our answers support American ideals of equality, class status should have no effect upon the distribution of mental illness in the population. Neither should it influence the kind of psychiatric treatment mentally ill patients receive. However, the reader should remember that our ideals and our behavior are two different things.

Both social class and mental illness may be compared with an iceberg; 90% of it is concealed below the surface. The submerged portion, though unseen, is the dangerous part. This may be illustrated by recalling what happened when an "unsinkable" trans-Atlantic luxury liner, the *Titanic*, rammed an iceberg on her maiden voyage in 1912. In that crisis, a passenger's class status played a part in the determination of whether he survived or was drowned. The official casualty list showed that only 4 first class female passengers (3 voluntarily chose to stay on the ship) of a total of 143 were lost. Among the second class passengers, 15 of 93 females drowned; and among the third class, 81 of 179 female passengers went down with the ship. The third class passengers were ordered to remain below deck, some kept there at the point of a gun.

The idea that stratification in our society has any bearing on the diagnosis and treatment of disease runs counter to our cherished beliefs about equality, especially when they are applied to the care of the sick. Physicians have deeply ingrained egalitarian ideals with their fellow citizens, yet they, too, may make subtle, perhaps unconscious judgments of the differential worth of the members of our society. Physicians, among them psychiatrists, are sensitive to statements that patients may not be treated alike; in fact there is strong resistance in medical circles to the exploration of such questions. But closing our eyes to facts or denying them in anger will help patients no more than the belief that the *Titanic* was "unsinkable" kept the ship afloat after it collided with an iceberg. . . .

The implementation of a decision that a person should be treated by a psychiatrist for his disturbed behavior is linked to class status. There is a definite tendency to induce disturbed persons in class I [the most affluent class, highly educated, consisting of business and professional leaders] and II [generally educated beyond high school, managerial positions, living in the better neighborhoods] to see a psychiatrist in more gentle and "insightful" ways than is the practice in class IV [the working class, engaged in skilled or semiskilled manual occupations, generally completed some high school]

and especially in class V [the lowest class; semiskilled factory hands and unskilled laborers who generally have not completed elementary school, living in the worst areas of town], where direct, authoritative, compulsory, and, at times, coercively brutal methods are used. We see this difference most frequently in forensic cases of mentally ill persons who are treated often according to their class status. The goddess of justice may be blind, but she smells differences, and particularly class differences. In sum, perception of trouble, its evaluation, and decisions about how it should be regarded are variables that are influenced in highly significant ways by an individual's class status. . . .

[A] distinct inverse relationship does exist between social class and mental illness. The linkage between class status and the distribution of patients in the population follows a characteristic pattern; class V, almost invariably, contributes many more patients than its proportion in the population warrants. Among the higher classes there is a more proportionate relationship between the number of psychiatric patients and the number of individuals in the population. . . .

Examination of each type of psychotic disorder shows a true linkage between class position and the rate of treated cases in the population, but the relationship is indirect: The lower the class, the higher the rate. The increases in rates are relatively small from class I-II to class IV for the alcoholic, the organic and the senile disorders. Between class IV and V, each of these disorders shows a sharp increase in each rate: incidence, reentry into treatment, continuity of treatment, and prevalence. There are no appreciable differences in the amount of affective disorders from class I through class III [middle-class families of average wealth], but from class II to class V there is a straight-line indirect relationship between the rate for affective disorders and class status. The sharp increases in the rates for each type of psychotic disorder between classes IV and V indicate clearly that something is operating in the society that gives rise to remarkable increases in the various kinds of rates at the class IV and V levels. . . .

The place where neurotic patients are treated is strongly associated with class status; the higher the class, the higher the percentage of disturbed patients treated by private practitioners. Treatment in public agencies is related inversely to class position: the lower the class, the greater the proportion of patients treated in public agencies. How patients are treated is linked to class position. Individual psychotherapy is a major treatment in all classes, but the lower the class, the greater the tendency to administer an organic therapy, shock treatment, lobotomy, or treatment with drugs. When the agency where the treatment takes place is held constant, the status factor continues to be important. Private practitioners administer analytic psychotherapy to the higher classes and directive therapies to the lower classes. The same class-linked gradient exists in the clinics, but not in the public hospitals. The number of times patients see their therapists per month, as well as the length of these visits, is significantly different from one class to another. The higher classes receive more frequent and longer treatments than the lower classes; the disparity is most marked between classes IV and V. . . .

This chapter has been focused on a series of tests of the proposition that class status is a significant factor in the treatment of mentally ill patients. We have found real differences in *where, how* and *how long* persons in the several classes have been cared for by psychiatrists. . . .

The data presented lead to the conclusion that treatment for mental illness depends not only on medical and psychological considerations, but also on powerful social variables to which psychiatrists have so far given little attention. . . . Psychotherapeutic methods and particularly insight therapy are applied in disproportionately high degrees to higher status neurotic patients being treated by private practitioners. Organic therapies tend to be applied most often to neurotics in classes III and IV. Among the psychotic patients treatment differences among classes are most marked for the schizophrenias contributing, in no small part, to the large number of chronic patients in class V who remain in state hospitals year after year. Class as a factor in the length of treatment is also marked in the affective disorders. The bulk of these patients receive organic therapy, that is, electro-convulsive treatment. This suggests that if, for a given disorder, there is a treatment available which is relatively effective, inexpensive, and technically simple, class differences may be reduced, but not eliminated. . . .

The data in this chapter establish that expenditures on treatment are linked in highly significant ways with class status in each type of psychiatric facility. In private practice, the higher the class, the greater the mean per patient expenditure. In private hospitals, the higher classes spend more than the lower classes because they are hospitalized longer. However, the mean cost per day is significantly less for the higher classes. This is attributable to discriminatory discounts granted to high status persons. In the clinics, the fees paid by classes II, III, and IV are not significantly related to class status. On the other hand, the cost to the clinic of treating patients is related inversely to class status. The clinics spend eight times as much treating each class II patient as they do each class V patient. This differential results from the varying amounts of treatments administered to patients in these classes. Public expenditures on patients in state hospitals are related to class position. This association is produced largely by the differences in the way the state hospitals are used by each class. In classes II and III, the patients are sent to the state hospital as a "last resort," and usually only after their families have exhausted their resources in private facilities. Class IV uses the state hospital as a treatment center as well as a place for custodial care. The state hospital is the one psychiatric facility available to class V persons who become so disturbed that they have to be separated from the community. Ordinarily, these persons are not wanted by their families, and they are viewed as useless, obnoxious, and occasionally dangerous to society, if not to themselves. The sequel to rejection by the family and isolation from the community is long-term custodial care. Thus, although the state hospital is a minimum-cost institution on a per diem basis, it is a maximum-cost institution; in the long run because it functions in a large part as a "dumping ground" for psychotic individuals in the two lower classes, especially class V. In sum, the class status of the patient influences expenditures on treatment in each type of psychiatric facility in highly significant ways. ■